Blueprint for Health

2/10/2022

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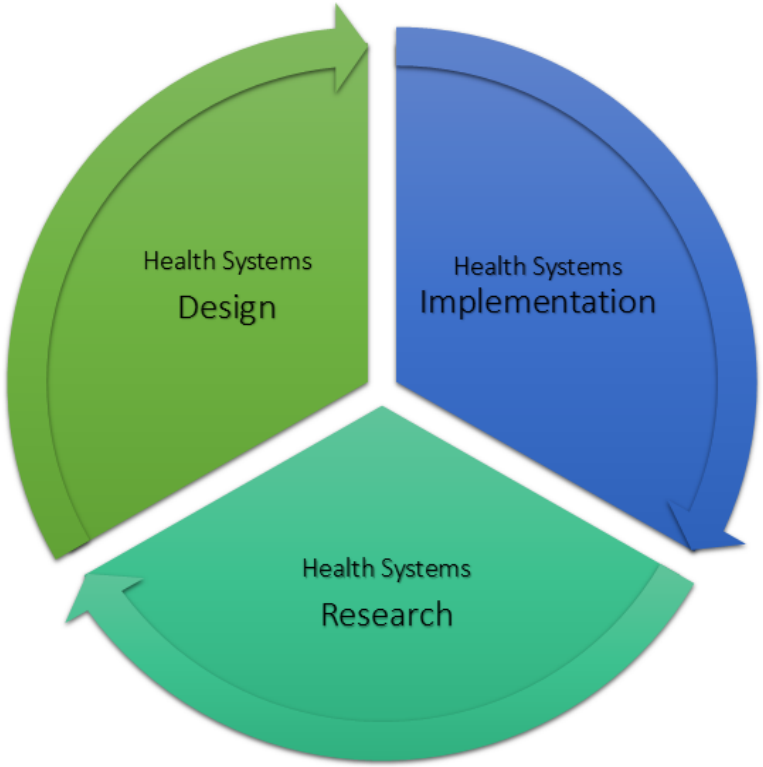
2010 -Vermont Statutory Framework
Act 128 Mission of Blueprint For Health
"integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management."

Innovate



- Establish and sustain a network that can systematically test and implement innovative community-led strategies for improving health and well-being
- Rapidly respond to Vermont's health and social service priorities through statewide implementation of new initiatives and service models
- Incorporate the innovation cycle - design, implementation, and research - into all initiatives and services

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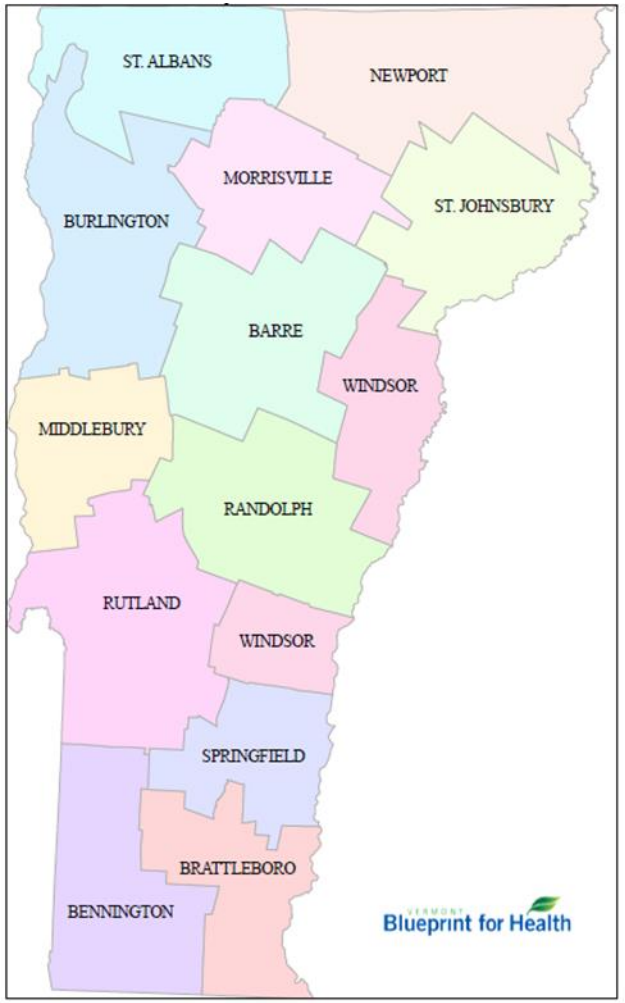
- The foundation of the Blueprint model is advanced primary care at the patient centered medical homes (PCMH) that meets patients' and families' needs to coordinate care seamlessly
  - Improve the health of the population
    - Screening for Social Determinants of Health
      - Food, Housing, Interpersonal Violence, Depression
    - Support patient to manage chronic health conditions
      - Hypertension, Diabetes, Asthma
- Enhance the patient experience of care
  - Access medical visit in which patients are asked about their reproductive, physical and emotional health and wellness
- Reduce the cost of care

Blueprint Executive Committee

The Blueprint Executive Committee shall provide high-level multi-stakeholder guidance on complex issues. The Blueprint Executive Committee shall advise the Blueprint Director on strategic planning and implementation of a statewide system of well-coordinated health services with an emphasis on prevention.

The Blueprint Executive Committee Members represent a broad range of stakeholders including professionals who provide health services, insurers, professional organizations, community and nonprofit groups, consumers, businesses, and state and local government. Committee Make-up example:
AHS members, Commissioner of MH, Private health insurers, Home health, Self insured employers.
-Full list is available in our Blueprint Manual

Statewide Network
Hospital or Health service areas (HSA)



- **Administrative Entity**
  - Key stakeholders agreed upon one administrative entity accountable for leading implementation and ongoing operations of the All-Payer Model (APM) and the Blueprint program in their HSA.
  - Administrative entity within each HSA will receive multi-insurer payments to support hiring of Community Health Teams and must be Centers for Medicare and Medicaid Services (CMS) eligible providers.
  - **Program Managers 13 HSA**
    - Community Health Team Leads

- **Quality Improvement Facilitators**

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Health Service Area Program Manager

- Grant to each administrative entity signed yearly
- Provides funds for the Program Manager salary, a Quality Improvement Facilitator (in some HSAs)
- The Program Manager has primary oversight and responsibility for data collection, entry and completion of reports
- Administrative support to administer CHT funds/staffing and to support PCMHs within the Health Service Area.
- Community Collaborative

Blueprint Programs

- Current Blueprint programs include
  - Patient-Centered Medical Homes
  - Community Health Teams
  - Hub & Spoke system of opioid use disorder treatment
  - Women's Health Initiative/ Pregnancy Intention Initiative

Patient Centered Medical Home
National Committee on Quality Assurance (NCQA)

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Blueprint Patient Centered Medical Homes (PCMH)

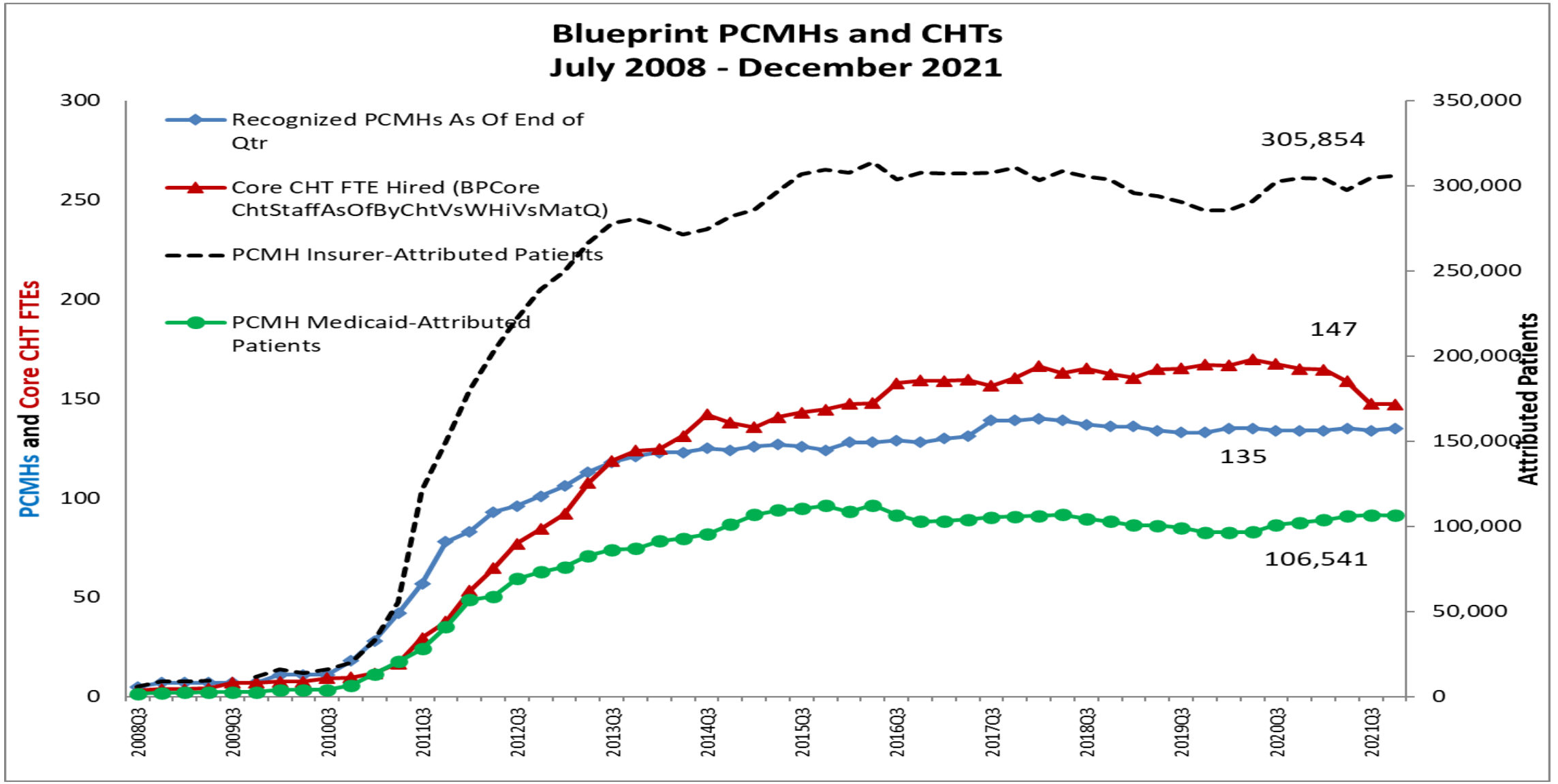
Active Engagement: Practices/Organizations annually pay a fee and register in a system called Q-PASS.

National Standards: Must achieve and sustain recognition as a PCMH from the National Committee on Quality Assurance (NCQA) to become and to maintain their status as Blueprint Advance Primary Care Practices. A copy of the standards can be found on the NCQA website at http://www.ncqa.org.

Continuous Quality Improvement: Ongoing transformation work as a medical home.

Quality Improvement Facilitator

- The Quality Improvement Facilitator helps engaging practices/organizations work through the continuous quality improvement process to:
  1. Achieve, maintain, and continue improvement on practice transformation as a Patient Centered Medical Home
  2. Help implement BP and other health care reform initiatives
  3. Meet standards and continue improvement on population health quality and payment reform efforts,
  4. Achieve and continue improvement on clinical, cost, or patient experience priorities identified by the practice



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PCMH Payments

As the result of **recognition as a PCMH**, practices receive payments from insurers for attributed lives in the practice (Per Member Per Month).PCMH payments are made directly to the practice by insurers.

PCMH Payments

1. Base payment ($3.00 PMPM commercial; $4.65 PMPM Medicaid; $2.05 PMPM Medicare).

2. Performance payment for **patient health care utilization** at the practice level (up to $0.25 PMPM; paid by commercial and Medicaid). The service utilization looks at the practice's resource use index (RUI) score. This score captures not only the number of services, but each service's relative weight based on how resource intensive it is, without the influence of price variation.

3. Performance payment for **quality measure** outcomes at the community or HSA level (up to $0.25 PMPM; paid by commercial and Medicaid). They include measures affected by community, social, and environmental factors:
   - Percent of adolescents with an annual well-care visit ;Health Effectiveness Data and Info set (HEDIS)
   - Percent of children up to three years of age who have had a developmental screening; National Quality Forum 1448 (NQF)
   - Percent of individuals with hypertension in control (NQF 0018);
   - Percent of individuals with diabetes in poor control (HgA1c > 9) (NQF 0059).

Payers Participating in Blueprint

Payers' Claims-Based Attribution Quarter: 2021-Q3	Payers' Claims-Based Attribution Counts For CHT
BCBSVT	98,379
Cigna	1593
Medicaid	106,579
Medicare	81,020
MVP	16,955
Total	304,526

Community Health Team

Community Health Teams support primary care providers in identifying root causes of health problems, including mental health and screening for social determinants of health.

Connect patients with effective interventions, support to manage chronic conditions, or provide additional opportunities to support improved well-being by engaging in team care

Funded Community Health Team

- Nurses
- Mental Health Clinicians
- Case managers
- Care Coordinators
- Panel managers
- Dieticians
- Community Health Workers

Larger Community is a Whole Health Team

- Designated Agency's
- Vermont Chronic Care initiative
- SASH
- VNA/Bayada
- Home Health Services
- Peers
- Food shelf
- Housing
- Many more…

CHT Payment Structure

- The investment in **CHT** capacity provides Vermonters with greater access to multi-disciplinary medical and social services in the primary care setting.
- Health Service Areas receive funds from insurers for staffing a **Community Health Team. ($2.77 PMPM commercial and Medicaid, and $2.51 PMPM Medicare, for core/primary care staffing).**
  - There are different models for staffing a Community Health Team. An Administrative Entity may decide to hire on their own, pass-through money directly to practices for hiring staff, or contract with another entity such as local Designated Agency.
- CHT payments are divided into 3 categories: core/primary CHT staff, MAT CHT staff, and Women's Health Initiative CHT staff.

Accountable Communities for Health

Purpose is to understand the current health status of the residents of the Health Service Area and establish clear, measurable, and actionable goals for improvement

- Costs of health care services used by those residents
- Structure of available health services
- Identify opportunities to improve health
- Lower costs
- Improve the delivery of health care services
- Improve patient experience

Accountable Community for Health (ACH) will address the medical and non-medical needs that affect measurement results and outcomes, including social, economic, and behavioral factors.

These needs and the impact they have on population health are routinely referred to as the Social Determinants of Health

Blueprint Programs

- **Hub and Spoke** provides opioid use disorder treatment
- **Women's Health Initiative(WHI)** increases pregnancy intention, healthy families

Hub and Spoke Medication Assisted Treatment (MAT)

Hub and Spoke is Vermont's system of Medication Assisted Treatment, supporting people in recovery from opioid use disorder.

Medication Assisted Treatment is considered a very effective treatment for most people

Federal regulations designate two settings where Medication Assisted Treatment can take place, Opioid Treatment Programs (OTPs) and Office Based Opioid Treatment (OBOT) settings

Hub & Spoke Program started in 2013

Hubs: Enhanced OTPs (Opioid Treatment Programs) 8 program sites

Dispense Buprenorphine & Vivitrol in addition to Methadone

Augment staffing for health home services (care managers, counselors, nurses, and psychiatry)

Monthly bundled rate for Methadone and health home services

Spokes Enhance OBOT (Office Based Opioid Treatment) (~75 practice sites with Spoke CHT staffing)

Prescribe Buprenorphine & Vivitrol

1 FTE RN & 1 FTE Licensed Addictions/Mental Health Counselor for 100 Medicaid Members provide health home services

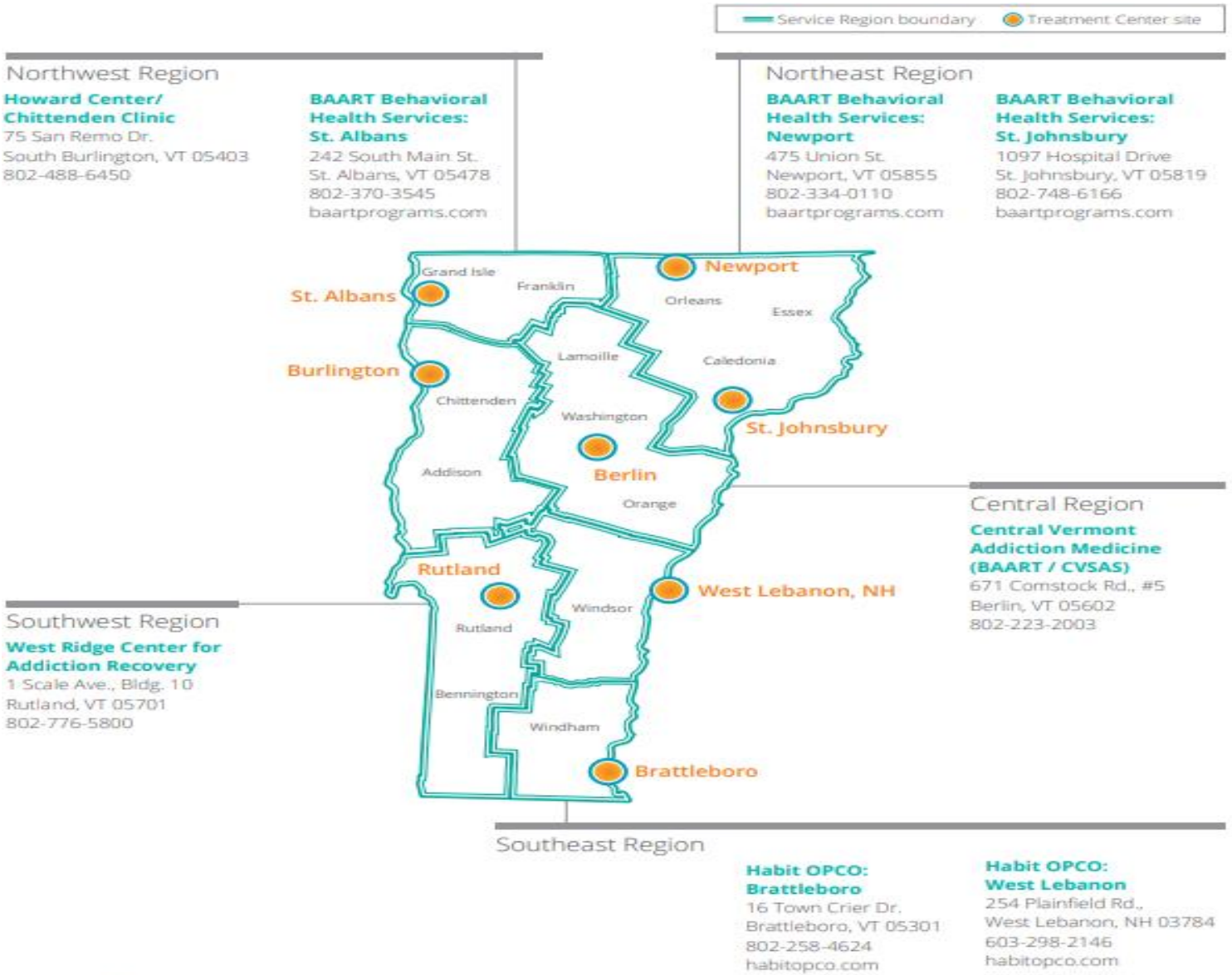
Hired and deployed as part of Blueprint Community Health Team though the administrative entity

Consultation between Hubs and Spokes

The expectation is that the patients move between Hubs and Spokes based on their clinical needs. In addition, the Hubs are expected to provide consultation support to the Spoke practices and to rapidly admit unstable patients referred from Spokes. In turn, as patients who receive Buprenorphine related products at Hubs stabilize, they are expected to be referred to Spokes for ongoing care. Coordination and engagement with PCP.

RAM: Rapid Access to Medication

Community initiatives where providers modify admissions and referral procedures with goal of initiation of medication within 3 days of contact at any community provider. Referrals across community providers for rapid initiation and ongoing system management and developed 12 community hospital ED's as new buprenorphine treatment access points with pre-determined clinical pathways out of ED's to community providers using support and engagement of recovery coach in the ED program.



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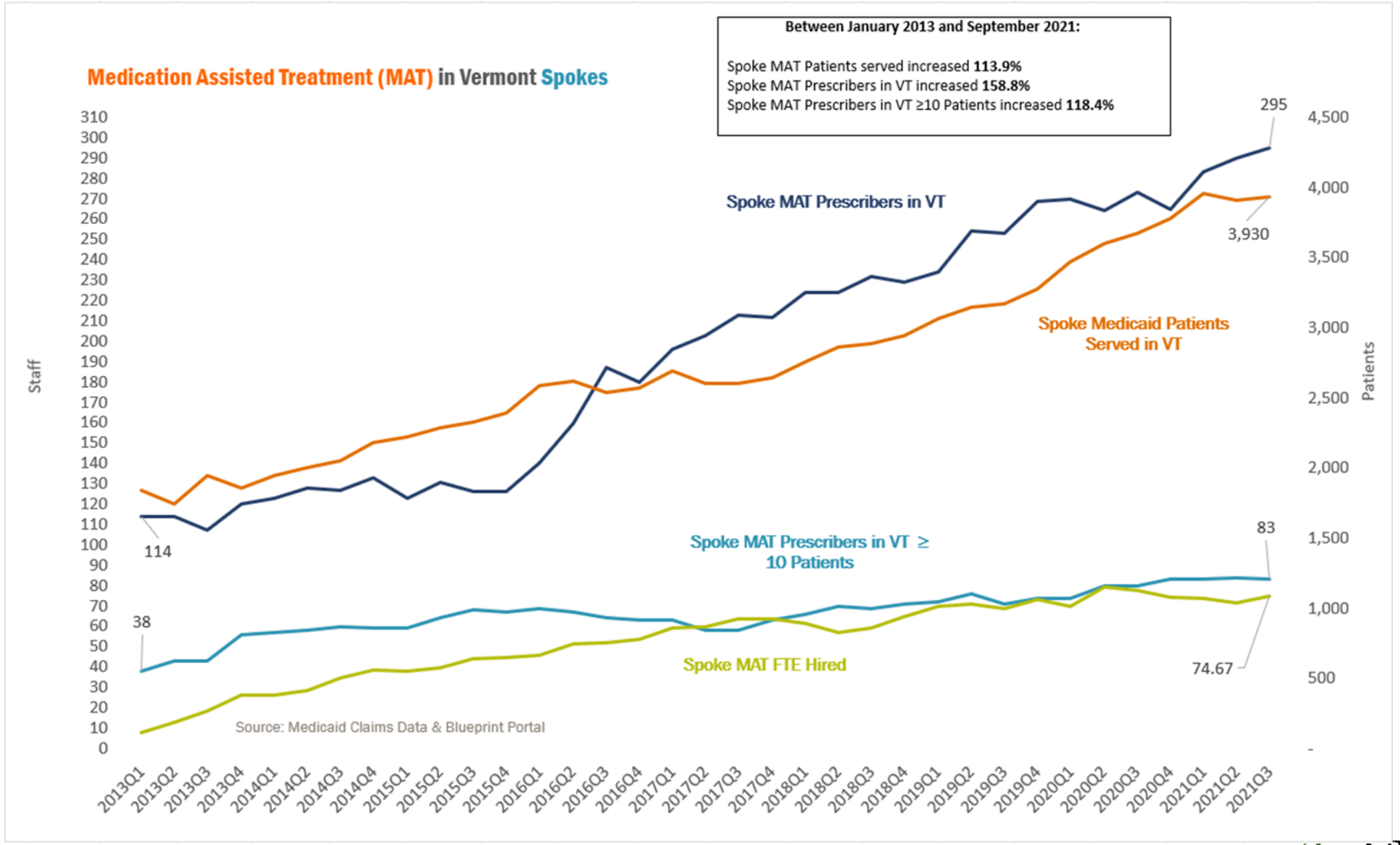

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Spoke RN: $85,000 (1 FTE per 100 Medicaid Patients)

- Assures patient has active relationship with PCP
- Coordinates and provides access to high quality health care services according to evidence-based clinical practice guidelines. Examples of health care issues that might be addressed:
  - Prevention of infectious diseases
    - HIV/Aids
    - Tuberculosis
    - STDs
    - Hepatitis C
- Additional indications for RN assessment, planning, intervention and evaluation:
  - Pregnancy/Pre-natal Care
  - Parenting Skills
  - Tobacco use/Cessation
  - Co-occurring Mental Illnesses
  - Dental Health
  - Chronic illnesses: HTN, Diabetes, Obesity, CAD, Chronic Pain, Depression
  - Nutrition
  - Personal Hygiene
- **Health Home Services**:
  - Comprehensive Care Management
  - Care Coordination
  - Health Promotion
  - Comprehensive Transitional Care
    - ER Utilization
    - Hospital Re-admission
  - Individual/Family Support
  - Referral to Community Services
  - Referral to Community Health Team
- **HEDIS Measures (To be required):**
  - Body Mass Index
  - Health Screenings
  - Tobacco Cessation Screening
  - Care Transition
  - HTN Control

Spoke Counselor: $55,000 (1 FTE per 100 Medicaid Patients)

- Must be either a licensed Social Worker, Mental Health Counselor, Marriage and Family Counselor, Psychologist, or other related Masters prepared and licensure recognized professional in Vermont.
- Provides initial cognitive/behavioral risk assessments
- Observes, describes, evaluates, and interprets behavior as it relates to substance abuse
- Constructs with client an action plan based on client needs
- Counsels and works with patient to modify harmful, addictive behaviors/lifestyle
- Facilitates and supports the client's choice of strategies that maintain treatment progress and prevent relapse
- Conducts home visits as needed
- **Health Home Services:**
  - Comprehensive Case Management
  - Care coordination
  - Individual/Family Support
  - Referral to Community Services (such as transportation, housing, parenting supports, job skills)
- **HEDIS Measure (To be required):**
  - Depression Screening
  - Care Transition

Supporting Pregnancy Intention and Healthy families Women's Health Initiative (WHI)
45% of all pregnancies to Vermont Resident Women are Unintended
Pregnancy Risk Assessment Monitoring System (PRAMS) 2018
Healthy Vermonters goal is to reduce the rate of unintended pregnancy to 35%

- Access to comprehensive family planning counseling

- Increased access to preconception counseling has been shown to improve maternal and infant outcomes. *One Key Question*
- Increased access to contraceptive counseling has been shown to be an effective intervention for reducing the rate of unintended pregnancies
- Same day access to long-acting reversible contraceptives (LARC) and/or moderate to most effective contraception

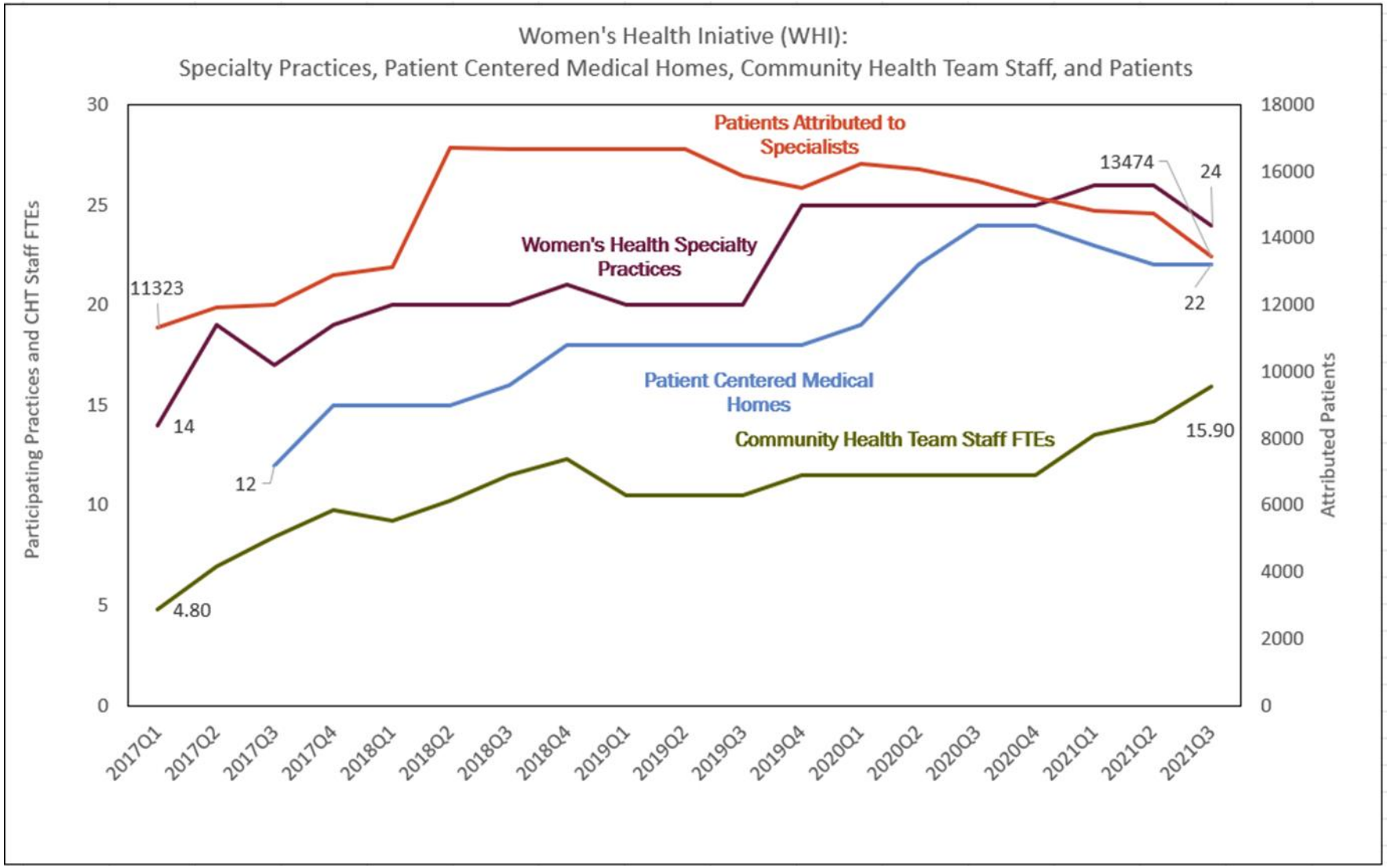
- Psychosocial screening, intervention, and navigation to services

- Integrated care interventions that include SDOH screenings
- Brief intervention and referral/navigation to treatment and services
- Care coordination agreements with Primary Care/ Community Partners

Payment Model for PCMH and Specialty Practices

- 45 Practices -24 Specialty which includes 12 Planned Parenthood of Northern New England (PPNNE) sites
- 3 forms of Medicaid payment based on attribution of people who can become pregnant ages 15 to 44:
  - Recurring per member per month (PMPM) payments to practices $1.25
  - Specialty clinics receive funds to hire a mental health clinician- At minimum a .5 FTE. For every additional patient the administrative entity receives $5.42 to allow increased staffing.
    - WHI PCMH have existing CHT staff support WHI goals
  - A one-time per member payment (PMP) to support stocking of most and moderate effective contraception such as Long-Acting Reversible Contraceptive (LARC) devices to practices.

More information available in our Women's Health Initiative Implementation Guide and Toolkit https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/WHIGuidedraft_4.21.21_0.pdf



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Research and Evaluation

- Community Profiles (https://blueprintforhealth.vermont.gov/community-health-profiles)
- Practice-Level analyses
- WHI Evaluation (https://blueprintforhealth.vermont.gov/womens-health-initiative-profiles)
- H&S/MAT Evaluation/Profiles (https://blueprintforhealth.vermont.gov/hub-and-spoke-profiles; https://blueprintforhealth.vermont.gov/reports-and-articles/journal-articles)
- Annual Report (https://blueprintforhealth.vermont.gov/annual-reports)

Population-Level Data Sources Utilized by Blueprint

- Practice/provider information and NCQA Patient-Centered Medical Home (PCMH) recognition statuses and dates from Blueprint field staff, via Blueprint web portal database.
- Deidentified claims data from Vermont Health Care Uniform Reporting and Evaluation (VHCURES) All-Payer Claims Database.
- Aggregate Blueprint patient-attribution counts and payment totals from insurers/payers and from VHCURES analyses.
- Identified Medicaid claims data from the VT Medicaid Management Information System (MMIS).
- Medicaid Accountable Care Organization (ACO) capitated payment data from the Dept. of Vermont Health Access (DVHA).
- VT Dept of Health Vital Records death registry information.
- Clinical data extract from Electronic Health Records via Vermont Information Technology Leaders (VITL).
- Patient-satisfaction survey data from Consumer Assessment of Healthcare Providers and Systems (CAHPS)PCMH Survey.

Resources

Blueprint for Health Manual and Implementation
https://blueprintforhealth.vermont.gov/implementation-materials

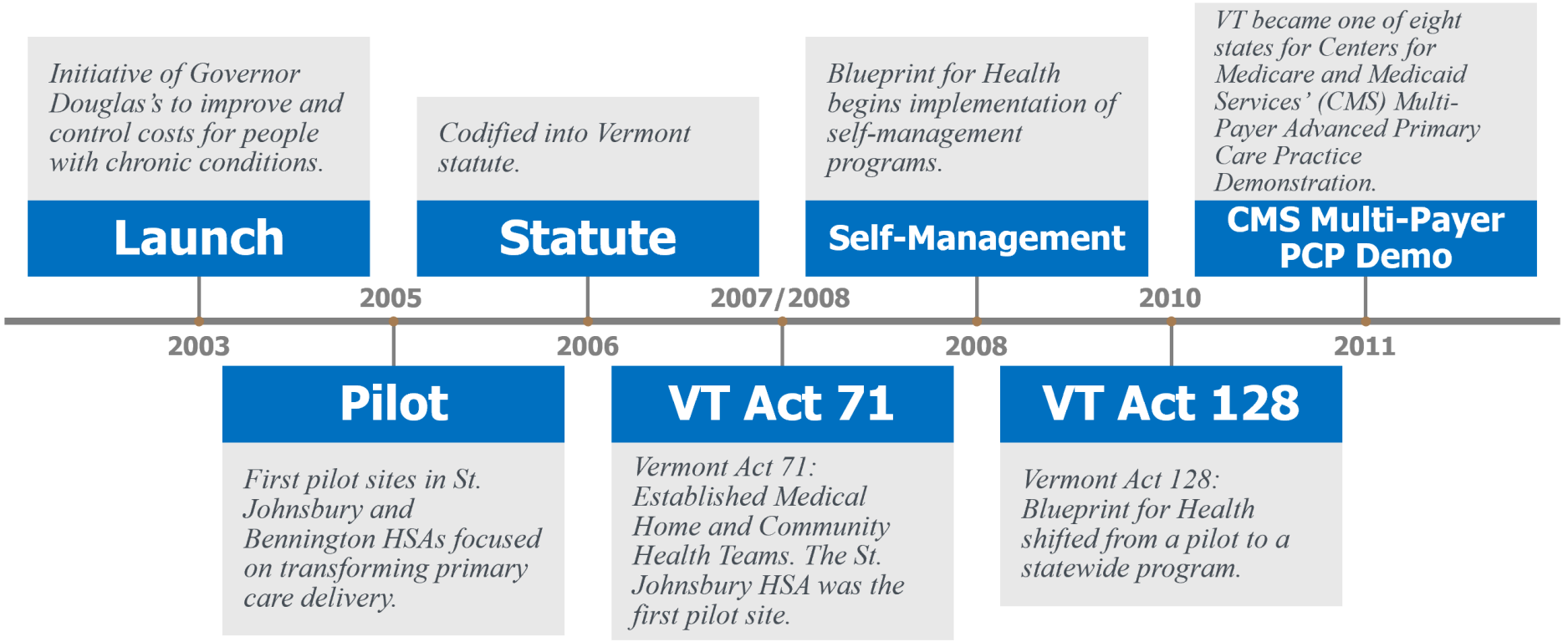
Blueprint Website
https://blueprintforhealth.vermont.gov/

Pregnancy Intention
https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/WHIGuidedraft_4.21.21_0.pdf

Hub and Spoke Manual
https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/SpokeGuide5172021.pdf

Contacts
https://blueprintforhealth.vermont.gov/contact-us

History of Blueprint for Health 2003-2011



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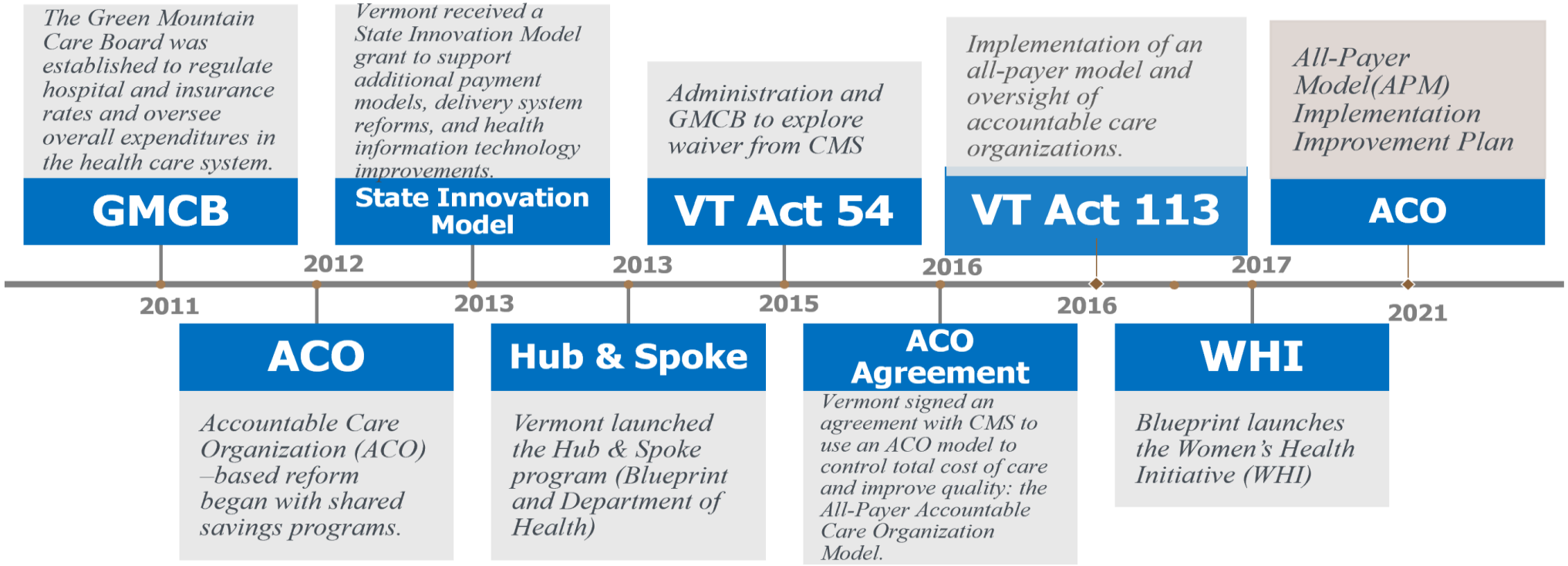
History of Blueprint for Health 2011-2021



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Questions/Thoughts

Thank you!

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